APPLEBY ELEMENTARY

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Authorization for Administration of Medication

A. **To be completed by parent or guardian:**

I request that my child ______________________, grade_____, receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other assigned person will administer the medication.

Signature (parent or guardian)____

Address:____

Telephone: Home:_______________ Work:______________ Date:_______________

B. **To be completed by the licensed health care provider:**

I request that my patient, as listed below, receive the following medication:

Name of Student:______________________________ Date of Birth:______________

Diagnosis:____

Name of Medication:____

Prescribed Dosage, Frequency and Route of Administration:

____

Time to be Taken During School Hours:____________ Duration of Treatment:_________

Possible Side Effects and Adverse Reactions (if any):___________________________

____

Other Recommendations:____

Name of Licensed Prescriber & Title (please print):___________________________

Prescriber's Signature:________________________________ Date:______________

Address:____ Phone:_____________